CONSENT FOR RELEASE OF CONFIDENTIAL INFORMATION

Forward To: HIP Health Plan of NJ, In Liquidation, 1 HIP Plaza, North Brunswick, NJ 08902, Tel # 1-800 _____

Patient Name:	Medical Record #
Address:	Date of Birth:
City, State, Zip:	Home/Work Tel.

I, _____, authorize HIP Health Plan of NJ, 1 HIP Plaza, North Brunswick, NJ 08902 to release to
(Name of Patient or Participant)

_____
(Name and Title of Person or Organization to whom Information is to be sent)

located at: _____
(address and telephone number of person or organization to whom information is to be sent)

the records of the above named patient. The patient has been treated at the following HIP Health Centers:

_____

Note: Where a request is made to send records to a health care provider, HIP will forward the complete, **original file to the office of that provider. Copies of records will be sent to all other recipients, with the **original file** to be archived until a request to send the record to a health care provider is received.

Purpose (need for information): ___ Patient Care, ___ Personal Use, ___ Fee, ___ Mail to Above Address, ___ Call for Pick-up _____.
(tel. no.)

If the patient has scheduled a visit with a non-HIP provider, and wishes his or her records to be forwarded to that provider, please indicate the date of that visit: _____.

BY SIGNING BELOW, I AUTHORIZE THE RELEASE OF THE PATIENT'S MEDICAL RECORDS. THIS AUTHORIZATION EXPIRES ONE YEAR FROM THE DATE IT IS SIGNED. I UNDERSTAND THAT IF I REQUEST THAT THOSE RECORDS BE SENT TO A HEALTH CARE PROVIDER, HIP HEALTH PLAN OF NEW JERSEY WILL FORWARD THE COMPLETE, ORIGINAL RECORD TO THAT PROVIDER AND WILL NOT RETAIN ANY COPIES OF THAT RECORD.

DATE: _____ SIGNED: _____
(Patient, age 18 or older)

SIGNED: _____
(Parent/Legal Representative/Relationship)

BY SIGNING BELOW, I INDICATE THAT I UNDERSTAND AND CONSENT TO THE RELEASE OF DOCUMENTATION AND/OR REPORTS IN MY MEDICAL RECORDS WHICH MAY INCLUDE ALCOHOL, DRUG ABUSE, AIDS/HIV INFECTION AND/OR PSYCHIATRIC CONDITIONS AND TREATMENT OF THESE DIAGNOSES. PATIENTS 14 AND OVER MUST SIGN FOR CONSENT TO RELEASE THEIR INFORMATION.

DATE: _____ SIGNED: _____
(Patient, age 14 or older)

SIGNED: _____
(Parent/Legal Representative/Relationship)

*Release of original X-ray films is **not** included in the medical record release. If you would like to receive your original x-ray films, you must request a separate radiology release form by calling 1-800- _____.

*Note to recipient of this information. You are prohibited from use of this information other than the purpose stated; prohibited from disclosing to any other party without written authorization from the patient or legal representative unless such information is urgently needed for the patient's continuing care or otherwise required by state law; and are required to destroy the information after the stated need has been fulfilled.